

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04856 11

CERTIFICATE OF DEATH

Reg. Dist. No. 52

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County... Calvert

City or town... Prince Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Calvert County Hospital

How long in hospital or institution?

3. (a) FULL NAME

Helen Alberta Cochran Bafford.

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

m

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

1871

8. AGE:

Years 76

Months

Days

If less than one day

.... hrs. min.

9. Birthplace

md.

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

Thomas Grierson

12. Name

Calvert Co

md.

13. Birthplace

Mary E. Hutchinson

14. Maiden name

Calvert Co

md.

15. Birthplace

Mrs Mary Anderson

16. Informant

S.C.

Address

Burial

(Burial, cremation, or removal. Which?)

Date thereof

6/15/47

(month) (day) (year)

Cemetery or location

St Paul

Location

Prince Frederick

Wm F. Hutchinson

18. Funeral director

Curry's

md.

Address

June 10

19 47

Date rec'd by registrar

Helen M.J. Bafford M.D.

Signature

M. D. or other

Address

Baltimore

Date signed

6/14/47

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland

County... Calvert

City or town... (If outside city or town limits, write RURAL and give nearest town)

Street No... (If rural, give LOCATION)

2.(a) If veteran, name war...

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

6/1/47 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to... 19...

and that I last saw h... alive on... 19...

Immediate cause of death... myocardial

failure

Due to... hypertension with

bilateral nephritis &

diabetic gangrene

Duration

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURES..... Address..... Date signed.....

M. D. or other

Address..... Date signed.....

6/14/47

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JUN 20 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

145

04857
51

Reg. Dist. No.....

1. PLACE OF DEATH:

County.....

Prince Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Calvert County Hospital

How long in hospital or institution?

8 weeks

3. (a) FULL NAME

Albert F. Bowen

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

W

W

B.(b) Name of husband or wife

Sally J. Bowen

7. Birth date of deceased (mo., day, yr.)

Apr. 10, 1866

6. (c) If alive, give age..... years

8. AGE: Years

Months

Days

If less than one day

81 2 19 hrs. min.

8. Birthplace

Calvert County, Md.

(Town, county, and state)

10. Usual occupation

Farming

11. Industry or business

Wiley W. Bowen

12. Name

MOTHER FATHER

13. Birthplace

Md.

14. Maiden name

Elizabeth Leckie

15. Birthplace

Md.

16. Informant

Shelton Bowen

Address

Barstow, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof July 1, 1947

(month) (day) (year)

Cemetery or crematory

Central

Location

Barstow, Md.

18. Funeral director

A. A. Harkness & Son

Address

Mutual, Md.

19.

6-36 1947

(Date rec'd by registrar)

H. W. Ward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Calvert

City or town.....

Barstow

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

WW

3. (b) Social Security Number

310

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 29, 1947 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18..... to..... 19.....

and that I last saw h..... alive on.....

Immediate cause of death.....

Sensitivity

Due to.....

Cardiac

Due to.....

Senile degeneration

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

23. SIGNATURE.....

Joe Villareal

M. D. or other

Address.....

S. T. Bernard

Date signed.....

June 30/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

04858

CERTIFICATE OF DEATH

Reg. Dist. No.

51

1. PLACE OF DEATH: *Calvert Hospital*
 County.....
 City or town..... *Prince Frederick md.*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....
 Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME *George J. Giles*

4. Sex <i>m</i>	5. Color or race <i>c</i>	6.(a) Single, married, widowed, or divorced <i>x</i>
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B.(b) Name of husband or wife *Hattie P. Giles*

7. Birth date of deceased (mo., day, yr.) *7, 1863* 6.(c) If alive, give age *54* years

8. AGE: Years *84* Months Days If less than one day
hrs.min.

9. Birthplace *md* (Town, county, and state)

10. Usual occupation *Farmer*

11. Industry or business

MOTHER FATHER 12. Name *Jerry Giles*

13. Birthplace *md*

14. Maiden name *Mary J. Parker*

15. Birthplace *md*

16. Informant *Hattie J. Giles*

Address *Owings, md.*

Burial *6-21-47* Date thereof *6-21-47*
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory *Mt. Hope*, Location *Calvert*

18. Funeral director *P.E. Seewell*

Address *Prince Frederick md.*

19. *6-21-47* Date rec'd by registrar *N.W. Wain* Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State *maryland* County *Calvert*
 City or town *Owings*
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *19 June* 1947, at *10³⁰* P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *1 June 1945* to *19 June 1947* end that I last saw him alive on *19 June 1947*

Immediate cause of death *Hypertension cerebral vascular*

rural disease

Due to *arteriosclerosis*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury _____ Injured at work?

23. SIGNATURE *Deeann* M. D. or other

Address *Philadelphia* Date signed *21 Jun 47*

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JUN 25 1947

BUREAU V-8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170c

04859

CERTIFICATE OF DEATH

Reg. Dist. No. 50

1. PLACE OF DEATH:

County

City or town

Calvert
Lusby

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John Wesley Gough

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

Black

Married

6. (b) Name of husband or wife

Catherine Gough

7. Birth date of deceased (mo., day, yr.)

March 11-1912

6. (c) If alive, give age

54 years

years

Months

Days

It less than one day

hrs.

min.

3.5 2 23

3.5 2 23

</div

RECEIVED

JUN 11 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

136

159

04860

Reg. Dist. No. 51

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....

CALVERT COUNTY

City or town.....

PRINCE FREDERICK

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

CALVERT CO. HOSPITAL

How long in hospital or institution?.....

3. (a) FULL NAME

Ligea
HillmanGraham

4. Sex

M

5. Color or race

C

6.(a) Single, married, widowed, or divorced

—

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

June 6 1947

8. AGE: Years

—

Months

—

Days

—

If less than one day

2 hrs. min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

JOSEPH GRAHAM

13. Birthplace.....

Calvert County

14. Maiden name.....

VIOLET GROSS

15. Birthplace.....

Calvert County

16. Informant.....

Joseph Graham

Address

Prince Frederick Md.

17. Burial (Burial, cremation, or removal. Which?)

Date thereof..... May 7 1947
(month) (day) (year)

Cemetery or crematory.....

Tanner Mausoleum

Location.....

Calvert Co. Md.

18. Funeral director.....

Joseph Graham

Address

Lakeside Mausoleum, Md.

19. June 7 1947 (Date rec'd by registrar)

H. W. Ward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MARYLAND County.....

CALVERT

City or town..... PRINCE FREDERICK

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

JUNE 6 1947 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to.....

19.....

and that I last saw h..... alive on.....

19.....

Immediate cause of death.....

Gastritis appears 3 to weeks

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury.....

Injured at work?

23. SIGNATURE

D. J. S. M.D. or other

Address..... Prince Frederick, Md. Date signed..... June 7 1947



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04861/40

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County *Cabinet*City or town *Prince Frederick*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *life*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? *2 days*

3. (a) FULL NAME

*William B. Gray*4. Sex *M* 5. Color or race *W* 6.(a) Single, married, widowed, or divorced *W*B.(b) Name of husband or wife *Sallie H. Gray*7. Birth date of deceased (mo., day, yr.) *June 29, 1863*8. AGE: Years *83* Months *11* Days *12* It less than one day *hrs. min.*9. Birthplace *Cabinet Co., Md*
(Town, county, and state)10. Usual occupation *Farmer*11. Industry or business *Lafayette Gray*FATHER 12. Name *Lafayette Gray*
13. Birthplace *Cabinet Co., Md*MOTHER 14. Maiden name *Katherine Powers*
15. Birthplace *Cabinet Co., Md*16. Informant *Bisces Gray*Address *Mutual, Md*17. Burial Date thereof *June 13, 1947*
(Burial, cremation, or removal. Which?) *(month) (day) (year)*Cemetery or crematory *Central*Location *Baltimore, Md*18. Funeral director *A. A. Harkness & Son*Address *Mutual, Md*19. Date rec'd by registrar *6-12 1947* *H. W. Ewart*
(Date rec'd by registrar) *Registrar*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md* County *Cabinet*City or town *Prince Frederick*
(If outside city or town limits, write RURAL and give nearest town)Street No. *220*
(If rural, give LOCATION)2.(a) If veteran, name war *WW*3. (b) Social Security Number *no*

MEDICAL CERTIFICATION

2D. DATE OF DEATH *June 11, 1947 at 4 A.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *19* to *19*,and that I last saw him alive on *19*.Immediate cause of death *Coronary Thrombosis*

DURATION

Due to *hypertension arteriosclerosis*Due to *hypertension arteriosclerosis*Other conditions *Hypertension arteriosclerosis*

(Include pregnancy within 3 months of death)

Major findings or operations *Date of op.*Autopsy results *Date of op.*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *Date of*Where did injury occur? *(City or town) (County) (State)*

Injured at home, farm, industry, public place (where?)

Means of injury *Injured at work?*23. SIGNATURE *K. W. Ewart* M. D. or other *June 12, 1947*Address *Date signed*

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JUN 18 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04862 /41
93d

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County.....

City or town.....

Calvert Hospital
Prince Frederick, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or Institution?.....

3. (a) FULL NAME

George S. Janey

4. Sex

m

5. Color or race

C

6.(a) Single, married, widowed, or divorced

X

6.(b) Name of husband or wife.....

Eliza Janey

6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.)

July 31, 1887

8. AGE: Years

60

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

md

(Town, county, and state)

10. Usual occupation.....

Farmer

11. Industry or business

MOTHER FATHER

12. Name..... Benjamin Janey

13. Birthplace.....

md

14. Maiden name.....

Mariah Hause

15. Birthplace.....

md.

16. Informant.....

Eliza Janey

Address

St. Leonard's, md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... 6-18-47

(month) (day) (year)

Cemetery or crematory.....

Brooks Chapel

Location.....

Calvert

18. Funeral director.....

P. E. Seewell

Address

Prince Frederick, Md.

19. (Date rec'd by registrar)

6-16-47

19-47

H. W. Ward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Calvert

City or town..... St. Leonard's, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 6-14-1947, at 10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12 June 1947, to 14 June 1947

and that I last saw him alive on 14 June 1947

Immediate cause of death..... Cerebral

Thrombosis

DURATION

Due to..... Hypertensive Cardio-
Vascular Disease

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

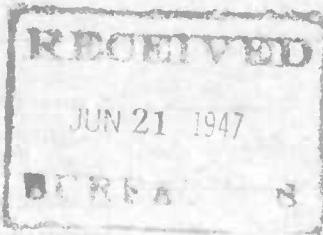
Means of Injury

Injured at work?

23. SIGNATURE.....

Thomas M. Dutelius, M.D. M. D. or other

Address..... Prince Frederick, Md. Date signed 18 June 1947



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important.—Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04863, ✓

CERTIFICATE OF DEATH

Reg. Dist. No. 5✓

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Walter W. Schuelen

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

W

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo. day, yr.)

6. (c) If alive, give age..... years

July 24, 1933

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

(Town, county, and state)

New York

10. Usual occupation.....

Student

11. Industry or business.....

MOTHER FATHER

12. Name.....

Frank Schuelen, Sr.

13. Birthplace.....

New York

14. Maiden name.....

Emily O. Hecker

15. Birthplace.....

New York

16. Informant.....

Sam Frank Schuelen

17. Burial.....

408 64th Ave Capt. Hgts Md.

(Burial, cremation, or removal, which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Oaklawn Cem. Balt. Md.

Location.....

W.W. Chambers Co.

18. Funeral director.....

517 11th St. S.E.

Address.....

June 17, 1947

Date rec'd by registrar.....

Registrar.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

County.....

Geo.

Capital Hgts.

Street No.....

408

64th Ave

(If outside city or town limits, write RURAL and give nearest town)

(If rural, give LOCATION)

2.(a) If veteran, name war.....

none

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 15, 1947, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to.....

19.....

and that I last saw him alive on.....

19.....

Immediate cause of death.....

Drowned

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of..... June 15, 1947

Where did injury occur?.....

(City or town)

(Country)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

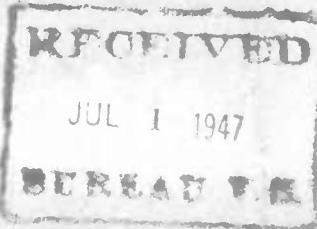
Injured at work?

23. SIGNATURE.....

Address.....

Date signed.....

6/18/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04864

137

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County.....

Baltimore, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution or street address where death occurred:

Cabinet, Rock
14 days

How long in hospital or institution?

3. (a) FULL NAME

John W.

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M

W

W

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

Washington, D. C.

(Town, county, and state)

10. Usual occupation.....

District Government

11. Industry or business

MOTHER FATHER

William Smithson

13. Birthplace

14. Maiden name.....

Mathews

15. Birthplace

16. Informant.....

Hospital Records

Address

Prince Frederick, Md

17. Burial (Burial, cremation, or removal. Which?)

Date thereof June 6, 1944
(month) (day) (year)

Cemetery or crematory.....

Cedar Hill

Location.....

Baltimore, Md

18. Funeral director.....

A. A. Harboe & Son

Address

Montgomery, Md

19. (Date rec'd by registrar)

9-4

15-47

H. W. Ward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md County.....

City or town.....

North Beach

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

Smithson

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

June 3 1947 at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 1945 to June 3 1947

and that I last saw him/her alive on June 2 1947

Immediate cause of death.....

Hemorrhage

Due to.....

Nephritis

(7/23/47 added)

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

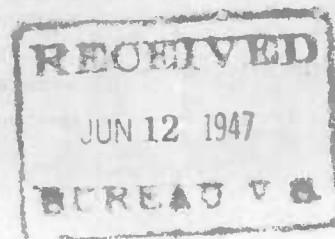
Means of injury

Injured at work?

23. SIGNATURE.....

Page J. H. M. D. or other

Prince Frederick, Md. Date signed 6/3/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04865

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CERTIFICATE OF DEATH

183
Reg. Dist. No.

51

1. PLACE OF DEATH:

County.....

Calvert

City or town.....

Darnell

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Charles M. Thomas

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

m

c

widowed

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Apr 30, 1914

8. AGE: Years

33

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

Wash. D.C.

(Town, county, and state)

10. Usual occupation.....

Hiderman

11. Industry or business

Walter Rama

12. Name.....

Wash. D.C.

13. Birthplace.....

Ada Thomas

14. Maiden name.....

Wash. D.C.

15. Birthplace.....

John Beard

16. Informant.....

Darnell

Address.....

Burial great Falls

Date thereof 7/3/47

(Burial, cremation, or removal which?)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

St. Mary's County

of E. Service

Prince Frederick, Md.

19. 7-3-1947
(Date rec'd by registrar)T-W Ward
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

Calvert

City or town.....

Darnell

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

June 30 1947 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on.....

19.....

Immediate cause of death.....

drowning

.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... accident Date of 6-30-47

Where did injury occur?..... Darnell Calvert Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)..... Home

Means of injury.....

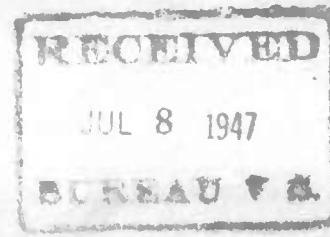
Injured at work? yes

23. SIGNATURE.....

Alvarez Deputy Medical Examiner M.D. or other

Germans, Md. Address.....

Date signed 7/3/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04866 # 138

CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH:

County Calvert

City or town Sunderland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Dora West

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widowed

Walter Scott West

7. Birth date of deceased (mo., day, yr.)

NOV 8, 1870

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Port Tobacco, Charles Co., Md.

(Town, county, and state)

10. Usual occupation

Hotel Proprietor

11. Industry or business

Hotel Business

MOTHER FATHER

12. Name

William Welsh

MOTHER

13. Birthplace

Charles County, Md.

FATHER

14. Maiden name

Sarah Owens

MOTHER

15. Birthplace

Charles County, Md.

FATHER

16. Informant

Melton Gordon

Address

Sunderland, Calvert Co., Md.

Burial

17. (Burial, cremation, or removal. Which?)

Date thereof June 13, 1947
(month) (day) (year)

Cemetery or crematory

Prospect Hill Cemetery

Location

Washington, D.C.

18. Funeral director

J. DeLamare Lee's Sons Co.

Address

300 - 1/2 st. N.E.

19.

6-10 1947
(Date rec'd by registrar)H. W. Ward
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Calvert

City or town Sunderland, Calvert Co., Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 June 1947 at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 Dec. 1946, to 9 June 1947.

and that I last saw her alive on 8 June 1947.

Immediate cause of death cerebral hemorrhage DURATION

Due to Hypertensive Cardio-Vascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, tell the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

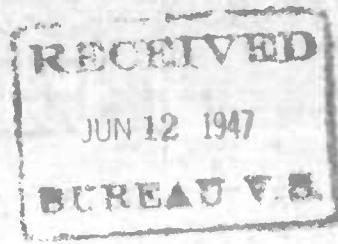
Means of injury

Injured at work?

23. SIGNATURE

Thomas M. Hutchins, M.D. M. D. or other

Prince Georges, Md. Date signed 10 June 1947



(I)

VS A15 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04867 # 143

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH: Calvert

County

City or town Dares.

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John Winston.4. Sex m. 5. Color or race C. 6.(a) Single, married, widowed, or divorced X6.(b) Name of husband or wife Sadie Winston7. Birth date of deceased (mo., day, yr.) April 1881 6.(c) If alive, give age 64 years8. AGE: Years 66 Months Days If less than one day hrs. min.9. Birthplace md. (Town, county, and state)10. Usual occupation Farmer.11. Industry or business P12. Name P13. Birthplace md.14. Maiden name Annie Wallace15. Birthplace md.16. Informant Sadie WinstonAddress Dares. md.17. Burial Date thereof 6-28, 47 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Browns.Location Calvert-18. Funeral director P.E. Sewell.Address Prince Frederick.19. 6-28 1947 (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CalvertCity or town Dares. (If outside city or town limits, write RURAL and give nearest town)

Street No. _____ (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 June 1947 at 8' p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 June 1944 to 20 June 1947 and that I last saw her alive on 26 June 1947Immediate cause of death Hepatitus Lent disease DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE I. W. Ward M. D. or otherAddress Huntington Rd. Date signed _____

